Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

October Term, 1994

ROBERT C. METCALF, DIRECTOR,
VIRGINIA DEPARTMENT OF
MEDICAL ASSISTANCE SERVICES,

Petitioner,

v.

REHABILITATION ASSOCIATION OF
VIRGINIA, INCORPORATED,

Respondent.

Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether health care providers have a private right of action under 42 U.S.C. § 1983 to challenge state Medicaid rates falling outside of the Boren Amendment.

2. Whether a state that uses its Medicaid funds to buy Medicare Part B coverage for its elderly and disabled poor may limit its reimbursement of coinsurance and deductibles under Medicare Part B, so that providers do not receive more than payment in full under established Medicaid rates.

3. Whether rehabilitation agencies that serve Medicaid patients in nursing homes may require a state to pay them directly for their services, especially when the legal duty for providing such services rests with the nursing home.

PARTIES BELOW

The parties to the proceeding in the Court of Appeals were as follows:

1. Rehabilitation Association of Virginia, Incorporated (Plaintiff-Appellee);

2. Bruce U. Kozlowski (later, Robert C. Metcalf), Director of Virginia Department of Medical Assistance Services (Defendant-Appellant); and

3. Donna E. Shalala, Secretary of Health and Human Services (Defendant-Appellant).

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PETITION FOR WRIT OF CERTIORARI

Robert C. Metcalf, Director of the Virginia Department of Medical Assistance Services,[1] hereby petitions this Court for a writ of certiorari to the United States Court of Appeals for the Fourth Circuit.

[1] Throughout most of the proceedings below, the Director of this Department was Bruce U. Kozlowski. An order formally substituting Mr. Metcalf for Mr. Kozlowski was entered by the Court of Appeals on December 21, 1994.

I. OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, dated December 5, 1994, is reported at *Rehabilitation Ass'n v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994) and is set forth at App. 1-71. The February 23, 1995 order of the Court of Appeals denying Virginia's Petition for Rehearing and Suggestion for Rehearing In Banc is set forth at App. 72-73. The March 23, 1995 order of the Court of Appeals withdrawing and staying its mandate is set forth at App. 74-75. The April 14, 1995 order of the Court of Appeals extending the stay of its mandate is set forth at App. 76-78.

The order and opinion of the United States District Court for the Eastern District of Virginia, dated November 22, 1993, are set forth at App. 79-81 and App. 82-107, respectively. The opinion is also reported at *Rehabilitation Ass'n v. Kozlowski*, 838 F. Supp. 243 (E.D. Va. 1993).

II. JURISDICTION

The Opinion of the United States Court of Appeals for the Fourth Circuit was issued on December 5, 1994. An Order denying Petitioner's timely request for rehearing and rehearing *in banc* was entered on February 23, 1995.

The jurisdiction of this Court to issue a writ of certiorari in this case is grounded in 28 U.S.C. § 1254(1).

III. CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case involves standing to sue under 42 U.S.C. § 1983. It also involves the construction and application of several provisions of Titles XVIII and XIX of the Social Security Act, respectively known as the Medicare Act (42 U.S.C. § 1395, *et seq.*) and the Medicaid Act (42 U.S.C.

§ 1396, *et seq.*). Pertinent parts of these statutes are set forth in the Appendix.

IV. STATEMENT OF THE CASE

A. Procedural Background

On June 7, 1993, Rehabilitation Association of Virginia, Inc., ("the Association") filed this suit against the Director of the Virginia Department of Medical Assistance Services ("Virginia") and Donna E. Shalala, the federal Secretary of Health and Human Services ("the Secretary"). Filed on behalf of Association members that perform rehabilitation services for residents of nursing homes, the suit sought injunctive relief to invalidate portions of Virginia's Medicaid plan and to compel Virginia (i) to pay at the Medicare rate rather than the Medicaid rate, and (ii) to make payments directly to its members rather than to the nursing homes. The Secretary was joined because Virginia's Medicaid plan had been approved by her pursuant to her interpretation of federal statutes and regulations. The United States District Court for the Eastern District of Virginia, Richmond Division, assumed jurisdiction of this matter pursuant to 28 U.S.C. § 1331.

On November 22, 1993, the District Court ruled in favor of the Association, ordering Virginia to pay rehabilitation providers at the Medicare rate and to pay them directly. The District Court also held invalid the Secretary's action approving Virginia's plan insofar as it provided for payment at the Medicaid rate and for payments to nursing homes rather than to rehabilitation providers. App. 80. Both Virginia and the Secretary appealed.

In a split decision, a majority of the Court of Appeals affirmed the opinion of the District Court. App. 2. On February 23, 1995, it denied Virginia's Petition for Rehearing and Suggestion for Rehearing In Banc. On March 23, 1995, the Court of Appeals withdrew its mandate for a period of 30 days or pending the filing of this petition. On April 14, 1995, it extended the stay of its mandate until this Court acts on Virginia's petition for writ of certiorari.

B. Statutory and Factual Background

Medicare is a federal program for persons age 65 or over and for disabled persons. It is composed of two parts. Part A deals with in-patient hospitalization and covers all persons who meet the age or disability criteria. Part B is an optional, supplemental program under which persons eligible for Part A may pay a premium and purchase insurance coverage for various out-patient services. Both parts involve annual deductibles and co-payment requirements.

Medicaid is a joint federal/state program for *poor* persons to obtain medical coverage, including both in-patient hospitalization, Part A, and various out-patient services, Part B. There is an *overlap* between the Medicare and Medicaid programs in that some persons may qualify for Medicare based on age or disability, and for Medicaid based on poverty. Since the poor are often unable to afford insurance premiums, Congress requires participating states to use some of their Medicaid funds to pay Medicare Part B premiums for their elderly and disabled citizens who are Medicaid-eligible. These persons are

sometimes called "dual eligibles" or Qualified Medicare Beneficiaries ("QMBs").[2] When a state buys Medicare Part B coverage for QMBs, it also undertakes an obligation – the extent of which is at issue in this lawsuit – to make payments toward the annual deductible and 20 percent co-payments ordinarily contemplated by Medicare Part B.

Health care providers who furnish services to Medicare and Medicaid patients are paid according to certain fixed rates geared to the service rendered. These rates are different for Medicare and Medicaid, with Medicare rates often being higher than Medicaid rates. Thus, the question arises: When Part B services are provided to a QMB, *which rate* is to be used in calculating the state's liability for the deductible and co-payments? For example, suppose that the Medicare rate for a certain Part B service is $1,000 and that the Medicaid rate for that same service is $900. When a health care provider furnishes that service to a QMB, the federal government pays the provider 80 percent of the Medicare rate, as it does for all Part B services. Eighty percent of $1,000 is $800. But, how much does the state pay? Two answers have been proposed.

1. *Virginia and the Secretary* maintain that the state has a duty to pay *only* enough to bring total payments *up to the Medicaid* rate of $900, a payment of $100. They base this position, in part, on the permissive language of 42 U.S.C. § 1396a(n) which allows – but

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[2] Participating states must also provide Part B Medicare coverage for its elderly and disabled poor who are *not* Medicaid eligible, but who still fall under the federal poverty line. This group is also known as "QMBs" or sometimes, "pure QMBs."

does not require – states to pay in excess of amounts ordinarily paid under their Medicaid rates. App. 113.

2. The *Association* argues that the state must pay the *remaining 20 percent of the Medicare rate* of $1,000, a payment of $200. It tries to support this argument largely by stringing together parts of two statutes, including § 1396a(a)(10)(E)(i), App. 112, which requires states to make "medical assistance" available for medicare cost-sharing for QMBs, and § 1396d(p)(3), App. 116, which defines "medicare cost-sharing" to include the difference between 80 percent and 100 percent of the Medicare rates. In so doing, the Association ignores, *inter alia*, § 1396d(a) which defines "medical assistance" to mean "payment of *part* or all of the cost" of covered services. App. 115 (emphasis added).

The position advocated by Virginia and the Secretary finds strong support in legislative history. In 1988, Congress transformed what had been an *optional* aspect of the Medicaid program into a *mandatory* one, requiring states to buy Medicare Part B coverage for their QMBs. Medicare Catastrophic Coverage Act, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748 (1988) (codified at 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(p). When Congress imposed upon the states these new Medicaid costs, it also explained the limits of these costs:

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligibles, some States pay the coinsurance even if the amount Medicare pays for the service is higher than the State Medicaid payment rate, while

> others do not. *Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare – i.e., 80 percent of the reasonable charge – exceeds the amount Medicaid would pay for the same item or service.* However, if a State chooses to pay some or all of the coinsurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

See, H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884 (emphasis added).

The same legislative report provides an example of how this ceiling on costs would work:

> [A]ssume that a physician actually charges a "buy-in" patient $60 for performing a particular procedure; that Medicare recognizes $50 as the reasonable charge; and that the State Medicaid program only pays $35 for this procedure. Whether or not the physician takes assignment, Medicare will pay only 80 percent of $50, leaving a $10 coinsurance obligation for the beneficiary. However, since the State only recognizes $35 as the fee for the procedure in question, and since the Medicare program has already paid the physician $40, the State is not required to pay any of the $10 coinsurance. If the State chooses to pay some or all of the $10, however, its cost would qualify for Federal matching payments at the regular rate for Services.

Id. at 884.

The Court of Appeals discounts this explanation of the 1988 amendments, pejoratively labeling it "post-enactment legislative history." App. 31. It is not. The quoted committee report was contemporaneous with Congress' decision to make mandatory what had previously been purely voluntary. As such, it is a fair statement of Congressional understanding about the major new obligation it was voting to impose on the states. *See generally* dissent by Niemeyer, J., App. 64 n.9. Congress could not have spoken more directly that it did in 1988: states are not obliged to pay 100 percent of the co-insurance and deductibles for QMBs and dual eligibles.[3]

Finally, Virginia's Medicaid plan, as approved by the federal Secretary, requires nursing homes serving Medicaid patients to provide rehabilitation services, which they may do with their own staffs or by contracting with outside rehabilitation agencies. Even when the nursing home chooses the latter option, Virginia does not pay the rehabilitation agency directly, but allows the nursing home to include its reasonable costs of obtaining such services in its annual cost reports, which then become the

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[3] Admittedly, not all legislative history favors Virginia and the Secretary. A committee report from 1986 – only two years earlier – appears to suggest a contrary understanding about what the *voluntary* buy-in program meant. App. 26-27. While the 1988 report is still the better evidence of what the *mandatory* program means, the fact that the House of Representatives could have two apparently contradictory committee reports within the space of only two years suggests that Congress may not pay much attention to what any of them say. Of course, discounting the committee reports simply underscores the need to defer to the Secretary in her understanding of what the legislation means.

basis for the state's payment to the nursing home. Whether Virginia's arrangement is valid, or whether the rehabilitation agencies are entitled to direct payment for their services to QMBs, as the Court of Appeals ruled, is an issue on which Virginia seeks *certiorari*.

V. REASONS WHY THE PETITION FOR WRIT OF CERTIORARI SHOULD BE GRANTED.

INTRODUCTION

Rule 10.1 of the Rules of this Court provides that a petition for writ of certiorari will be granted only when there are special and important reasons for doing so. Rule 10.1(c) lists among such reasons a decision by a federal court of appeals on an important question of federal law which has not been, but should be, decided by this Court.

This case presents questions that meet the foregoing criterion. Recent federally-mandated growth of state Medicaid programs, inflation of health care costs and the growing needs of our elderly indigent population have combined to create an unprecedented demand for Medicaid services. As demands for Medicaid services have grown, so too have grown the disputes between Medicaid programs and health care providers seeking increased payments for their services.

While the Court of Appeals' decision follows rulings by other circuits, there is considerable dissension in the federal judiciary on the Medicaid rate limitation issue raised by this petition. Three trial courts have affirmed the Secretary's interpretation before being overturned on appeal. Two of those trial courts affirmed the Secretary even after a divided Second Circuit, the first appellate court to hear the issue, rebuffed the Secretary. Similar suits are currently pending in the federal district courts in Maryland, Illinois and Michigan.

Under the precedent followed by the Court of Appeals, the federal courts may well become the primary avenue by which health care providers will obtain increased payments for their services, effectively displacing the discretion traditionally afforded to executive branch agencies in their administration of a complex legislative scheme. Such a result would not only represent an inappropriate expansion of the role of the judiciary, it would bring financial uncertainty and potential disruption to the states, which have received and depended upon approval of their Medicaid plans by the federal Secretary. Final and timely resolution of the important national issues of law presented by this appeal will provide valuable guidance to the states – and to Congress – as they debate and decide their future roles in the delivery of health care to our elderly and indigent populations.

A. The Court of Appeals Disregarded The Basis For The *Wilder* Decision, and Improperly Expanded The Right Of Health Care Providers To Sue For Increased Rates.

This case presents a question of substantial importance to the future of Medicaid programs nationwide. In *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990), a 5-to-4 majority[4] of this Court decided that health care providers have standing to bring private actions under 42 U.S.C. § 1983 to enforce the Boren Amendment to the Medicaid Act. At issue today is whether standing under *Wilder* will be dramatically expanded, so that health care providers *not* covered by the Boren Amendment will nevertheless be able to challenge the reimbursement rates of a state Medicaid plan in federal court.

The Medicaid Act does not create an express right of action for health care providers. In *Wilder*, this Court found an implied right to sue under the Boren Amendment, a 1980 addition to the Medicaid Act found at 42 U.S.C. § 1396a(a)(13)(A).[5] App. 112. *Wilder* did not require

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[4] The majority included Justices Brennan, White, Marshall, Blackmun and Stevens. The dissenting opinion was written by Chief Justice Rehnquist, with whom Justices O'Connor, Scalia and Kennedy joined.

[5] Enacted in 1980, the Boren Amendment changed the standard for reimbursing nursing and intermediate care facilities. Pub. L. 96-499, § 962(a), 94 Stat. 2650. In 1981, the Boren Amendment was extended to hospitals. Pub. L. 97-35, § 2173, 95 Stat. 808. In 1987, it was extended to cover intermediate care facilities for the mentally retarded. Pub. L. 100-203, § 4211(h)(2)(A), 101 Stat. 1330-205. It has never been extended to cover rehabilitation agencies.

the Court to address whether such a right exists under those portions of the Medicaid Act falling *outside* that amendment. The distinction is crucial, but the Court of Appeals ignored it. The plaintiff here did not sue under Boren, but under entirely different Medicaid provisions found at 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(a) and 1396d(p). App. 112 and 115; *see also* App. 12. In deciding – without analysis – that *Wilder* allows health care providers to sue under these statutes, the Court of Appeals abrogated the basic rule that "each statute must be interpreted by its own terms." *Suter v. Artist M.*, 503 U.S. 347, 358 (1992). As a result, Medicaid has been judicially restructured to the detriment of Virginia and other states that participate in this important program.

In *Cort v. Ash*, 422 U.S. 66 (1975), *Wright v. Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418 (1987), and *Wilder*, this Court instructed federal courts how to decide whether a particular plaintiff is entitled to sue under § 1983 when, as here, the underlying federal statute on which the claim is based is silent. An alleged violation of federal law is not enough to confer standing.[6] *Wilder*, 496 U.S. at 509 (citing *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103 (1989)). The proper focus is whether the plaintiff, here an association of rehabilitation agencies, is part of the special class for whose benefit the statute was enacted.

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[6] Virginia vigorously denies that it has violated Medicaid law. The federal Secretary, who has responsibility for assuring compliance by the states, agrees.

The original legislative history of the Medicaid Act contains no evidence that Congress intended the Medicaid Program to benefit health care providers. S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943.[7] On the contrary, the legislative record shows that the basic mechanism for assuring that states comply with the Medicaid Act is the oversight authority vested in the Secretary.[8] It was only by virtue of the Boren *Amendment*, a later addition to the Medicaid Act, that certain health care providers obtained the limited right to sue recognized by this Court in *Wilder*.[9]

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[7] The stated purpose of the Medicaid Act is:

> For the purpose of enabling each State, as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .

42 U.S.C. § 1396.

[8] Her authority includes the power to approve plans that comply with the requirements of the Medicaid Act, and to stop federal funding when a plan has been so changed that it no longer complies. *See* 42 U.S.C. §§ 1396a(b) and 1396c; App. 113 and 114.

[9] Although *Wilder* contains comments to the effect that providers had a right to sue for reasonable rates even before the passage of the Boren Amendment, 496 U.S. at 516, 517, 522 n.19, those comments are mere *dictum*. They cannot be said to represent a settled decision by this Court, especially given the dissenting opinion by four of the five Justices in the *Wilder* decision still sitting on this Court. That dissent concluded that, even after

While the Boren Amendment may have been adopted for the benefit of certain providers, the statutes at issue in the case at bar were not. This distinction can be readily seen through a comparison of the language chosen by Congress in each case. The Boren Amendment provides:

> A State Plan for Medical Assistance must – provide – for payment . . . of the *hospital* services, *nursing facility* services, and services in an *intermediate care facility* for the mentally retarded . . . [which] are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated *facilities*. . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added).

This explicit focus on the facilities that provide services stands in sharp contrast to the statutes on which the Association relies, where the focus is on the beneficiaries of medical assistance:

> A State Plan for Medical Assistance must – provide – for making medical assistance available for medicare cost sharing (as defined in [42 U.S.C. § 1396d(p)(3)]) *for qualified medicare beneficiaries* described in [42 U.S.C. § 1396d(p)(1))].
>
> § 1396a(a)(10)(E)(i) (emphasis added).

In *Wilder*, the Court emphasized the statutory references to facilities as the basis for its conclusion that

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Boren, the Medicaid Act "does not clearly confer any substantive rights on Medicaid services providers." 496 U.S. at 527. While *stare decisis* may preclude this Court from revisiting the holding in *Wilder*, it does not preclude this Court from *limiting* that decision to the distinct portion of the Medicaid Act then before it, i.e., the Boren Amendment.

"health care providers are the intended beneficiaries of the Boren Amendment." 496 U.S. at 510. Using the same logic, the reference to "qualified medicare beneficiaries" and the absence of any reference to "facilities" leaves little doubt that providers are not the intended beneficiaries of the statutes at issue here.

This case presents this Court with an opportunity to limit the application of *Wilder*, and thereby curtail health care providers in their burgeoning attempts to use the federal judiciary to win raises they cannot obtain from either the executive or legislative branches of their state and federal governments.[10] *Certiorari* should be granted.

B. The Court of Appeals Has Disrupted The Medicaid Program By Substantially Increasing Its Costs, and By Denying States The Ability To Rely Upon Approval Of Their Plans By The Federal Secretary.

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Rehabilitation Ass'n, 42 F.3d at 1450; App. 12.

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[10] *See* n. 16, *infra*, for list of known cases pending.

The Court of Appeals may be correct in this description of the statutory morass that is the subject of this case. It is certainly correct in acknowledging that the Secretary, whose arguments Virginia adopted below, "offers a reasonably good explanation . . . of the statutes over time. . . . " *Id.* at 1450; App. 14. The error by the Court of Appeals is that it fails to defer to the Secretary's "reasonable explanation" of those "impenetrable texts" but adopts the competing explanation of the Association, even while declaring that "[n]either interpretation is particularly satisfying." *Id.* at 1454; App. 24. *See* dissent at App. 45.

Such an approach is at odds with the doctrine of deference to expert administrative judgment, as enunciated by this Court in *Chevron, U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

467 U.S. at 842-43 (footnotes omitted).

While the Court of Appeals perfunctorily acknowledges this doctrine, its opinion is an extended exercise in imposing its own construction on the statute. As Judge Niemeyer wrote in his dissent:

> The majority concludes erroneously, I submit, that because it can string together *a* reading of the text which supports its position, it has proven that "Congress has directly spoken to the precise question at issue," and thus satisfied the first inquiry under *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 842 (1984). . . .
>
> * * * *
>
> Indeed, the fact that well-intentioned and intelligent experts at legal exegesis have arrived at three or four seemingly plausible readings of a particular text may be the best evidence that this interpretive puzzle has no definitive answer.

Rehabilitation Ass'n, 42 F.3d at 1462; App. 46 (emphasis in original).

In addition to the general rule set forth in *Chevron*, there are particular factors that require *even greater* deference to agency interpretation: (1) One such factor is when the agency is charged with administering a "complex and highly technical regulatory program." *Pauley v. BethEnergy Mines*, 501 U.S. 680, 697 (1991); (2) Deference is also particularly appropriate in the area of welfare administration. *See Mowbray v. Kozlowski*, 914 F.2d 593, 598 (4th Cir. 1990); (3) As Judge Niemeyer urges, extra deference should also be granted when a judicial decision has "major financial ramifications." App. 70; and (4) To

this list, Virginia would add that deference is especially appropriate when, in the administration of a jointly-funded program, federal and state agencies agree on the meaning of the statutes that form the contractual basis for their cooperation. *See generally Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.")

In light of these factors, it is hard to imagine a case crying out for deference more than this one does. Medicaid's "impenetrable texts" make it an example *par excellence* of a complex and highly technical regulatory program. Moreover, it is a welfare program involving the expenditure of astronomical sums;[11] and there is perfect agreement between Virginia and the federal Secretary as to the scope of state obligations. If deference is not granted here, then *Chevron* truly stands for nought. States will hereafter participate in federal programs at their peril, never knowing when the agency explanation of a murky statute will be supplanted by a more onerous explanation imposed by the courts. Indeed, as Judge Niemeyer noted, the decision by the Court of Appeals will cost the taxpayers an additional $10 million, half being paid from the state treasury and half from the

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[11] In federal fiscal year 1993 (the last year for which totals are available), the United States government spent nearly $102 billion on the Medicaid program. U. S. Department of Health and Human Services, HCFA Publication 10129, MEDICAID STATISTICS, PROGRAM AND FINANCIAL STATISTICS, FISCAL YEAR 1993 (October 1994). During the current state fiscal year, Virginia will spend more than $1 billion of its *own* tax dollars on Medicaid. Ch. 966, item 395 Va. Acts 2014, 2209-2210.

federal. App. 70.[12] These figures are for the Virginia program alone, and only for one year. Multiplying that impact over the years and across the many states with similar Medicaid programs quickly runs the impact up into the billions of dollars.[13]

The Court of Appeals has caused additional disruption by ruling that the rehabilitation agencies are entitled to direct payment from the states. This ruling undermines the Virginia Medicaid plan, as approved by the Secretary, which makes the nursing homes legally responsible for providing these services and precludes direct payment to outside agencies. Such a ruling not only allows the nursing homes to avoid their legal responsibilities to be the providers of rehabilitation services, it enables the rehabilitation agencies to escape the strictures of 42 U.S.C. § 1396a(a)(32), which largely precludes third-parties from receiving Medicaid payment, (App. 113), and it unfairly deprives the states of their oversight over the selection of Medicaid providers. *See Danvers Pathology Assocs. v. Atkins*, 757 F.2d 427 (1st Cir. 1985).

The Court of Appeals acknowledges that Medicaid is "essentially a payer of last resort. . . . " *Rehabilitation*

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[12] Virginia's contribution to the Medicaid program, which currently exceeds 13.8 percent of Virginia's general fund biennial budget, is a matter of great concern to the Commonwealth. Ch. 966, 1994 Va. Acts 2014.

[13] These figures represent only the prospective liability. While the 11th Amendment precludes federal courts from imposing retrospective monetary liability on the states, health care providers may nevertheless march into state courts with a federal precedent in hand and seek money judgments there. The plaintiff in the case at bar apparently intends to do so.

Ass'n, 42 F.3d at 1447; App. 5. Yet, this important principle of Medicaid law, allowing a state to conserve its financial resources, is an outgrowth of a larger fiscally conservative principle, ignored by the Court of Appeals, that requires participating states to provide medical assistance only "as far as practicable under the conditions in such State. . . . " 42 U.S.C. § 1396. Requiring the state to use its Medicaid dollars to pay at the higher federal Medicare rate, rather than at its own Medicaid rate is inconsistent with this fiscally conservative, fundamental principle and thereby distorts the Medicaid program. *Certiorari* should be granted and Medicaid returned to the basic principles.

C. The Divided Decision By The Court of Appeals Reflects A Protracted Disagreement Within the Federal Judiciary.

The statutory interpretation by the federal Secretary is very much alive. Although the Fourth Circuit is not the first court to deny the Secretary deference on this issue, the history of this and similar cases reveals a sharply divided federal judiciary. The Fourth Circuit's decision is the spawn of *New York City Health & Hosp. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992), *cert denied*, ___ U.S. ___, 113 S. Ct. 461 (1992).[14] So, too, are *Pennsylvania Medical Soc'y v.*

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[14] In *Perales*, the State of New York failed to raise the standing issue, an omission that may have contributed to the decision by this Court not to grant *certiorari*. Moreover, the Solicitor General advised the Court that, while he believed the court of appeals reached the wrong result, he did not advocate review by this Court at that time. His position was based on the fact that

Snider, 29 F.3d 886 (3d Cir. 1994) and *Haynes Ambulance Serv., Inc. v. Alabama*, 36 F.3d 1074 (11th Cir. 1994), which also denied deference to the Secretary. At work in *Perales* and its progeny is a misplaced concern by the courts that awarding providers the higher, Medicare rates is necessary to assure adequate health care for the elderly and disabled poor. In *Perales*, the majority wrote:

> Deeming dual eligibles and QMBs to be primarily Medicaid rather than Medicare patients prevents health care providers from collecting their reasonable costs or charges. *Providers will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor. These groups are the true subjects of this appeal*, and such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act.

954 F.2d at 859 (emphasis added).

The district court in the case at bar expressly embraced this theory. *Rehabilitation Ass'n*, 838 F. Supp. at 254; App. 107. While disclaiming any intention to make a policy choice, the Fourth Circuit also felt compelled to suggest that the Secretary's interpretation is hostile to the poor:

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other cases presenting the same question were pending, and he believed it appropriate to await further litigation developments before the question was addressed by this Court. While the Solicitor General has expressed no views on the case at bar, attorneys for the federal Secretary advised the Court of Appeals that a petition for certiorari "would present a substantial question for Supreme Court review." Letter of Richard A. Olderman, Esquire, dated March 10, 1995. App. 108.

> [T]he dividing line is essentially poverty: better payment goes to those serving the eligible "rich," while worse payment comes from serving the poor of whatever age.

42 F.3d at 1459; App. 38.

While concern for the poor is laudable, it should not be a factor in these cases. Nowhere does *Perales* or any of its progeny cite any *evidence* to show that health care providers in general – or rehabilitation agencies in particular – render inferior service based on the difference between Medicare and Medicaid rates. In his *Perales* dissent, Judge Cardamone hit the nail on the head:

> The majority's concern that crossovers and QMBs not be deprived of important medical care is misplaced. First, it does not follow that because crossover and QMB Part B service providers are reimbursed at the Medicaid rather than the Medicare rate there will be inadequate financial incentive to provide such care. Although admittedly with less incentive fewer providers will offer such care, that is not the crucial question. What is critical is whether reimbursement at the Medicaid level is so low that an "insufficient" number of providers will have a financial incentive to provide services. Nothing in the record supports such a dire conclusion.

Perales, 954 F.2d at 866 (Cardamone, J., dissenting) (citation omitted).

Moreover, there is a specific federal statute, 42 U.S.C. § 1396a(a)(30)(A) which insures that "payments are . . . consistent with . . . quality of care and are sufficient to enlist enough providers" so that care and services are equal to what is available for the general population.

App. 112. Nowhere has the plaintiff alleged that this statute has been violated by Virginia in setting its Medicaid rates. The issue here is more money for the providers, *not* better services for the poor.

The agreement among four circuits masks significant disagreement within the federal judiciary on whether to afford the Secretary deference. In *Perales*, No. 87 Civ. 4896 (MJL), 1991 U.S. Dist. Lexis 3167 (S.D.N.Y. Mar. 18, 1991), the trial court decided in favor of the Secretary, only to be overturned by the Court of Appeals in a split decision. In his strong dissent, Judge Cardamone emphasized the "ambiguous and conflicting provisions of the Medicare and Medicaid Acts." *Perales*, 954 F.2d at 864. After *Perales*, two district courts echoed Judge Cardamone's rationale before being reversed on appeal. *Haynes*, 829 F. Supp. 590 (M.D. Ala. 1993) and *Snider*, No. 1:CV-92-0481, 1993 U.S. Dist. Lexis 19613 (M.D. Pa. Nov. 2, 1993).[15]

Given this disagreement within the federal judiciary, litigation in the other courts is sure to follow. At least three such cases are now pending.[16] More cases shall surely arise as additional health care providers seek to obtain raises for their services from the federal judiciary, while state and federal governments struggle to keep

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[15] Copies of the three district court decisions deferring to the Secretary's interpretation are included in the Appendix at 118, 134 and 151.

[16] *Michigan Ass'n of Ambulance Servs. v. State of Michigan*, No. 5:95-CV-48 (W.D. Mich. filed Apr. 10, 1995); *Maryland Psychiatric v. Shalala*, No. 595-894 (D. Md. filed Mar. 24, 1995) and *Paramount Health Sys. v. Wright and Shalala*, No. 95-C-1620 (N.D. Ill. filed Mar. 14, 1995).

down the rising costs of health care. A timely decision by this Court supporting the Secretary's view would not only be legally correct, it would assist these nationwide efforts to control costs and eliminate the uncertainty states now face.

VI. CONCLUSION

The Court of Appeals has granted standing where it should have denied it, and has denied deference where it should have granted it. Moreover, it has imposed an incorrect reading of the law which dramatically increases the financial costs of the Medicaid program and undermines the certainty necessary for its orderly administration.

WHEREFORE, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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